DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/17/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	660 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual recertification survey conducted and complaint investigation #28183 August 1 - 3, 2011, at Center on Aging, Erwin, TN., no deficiencies were cited in relation to complaint #28183, under 42 CFR Part 482.13, Requirements for Long Term Care.	F 000	The submission of this POC does not, in any way, offer any admission that any deficiencies exist at The Center on Aging and Health	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to assess for the use of a restraint for one resident (#3) and failed to assess for restraint reduction for one resident (#4) of thirty-two residents reviewed. The findings included: Resident # 3 was admitted to the facility on May 20, 2010, and readmitted on July 6, 2011, with diagnoses of Congestive Heart Failure, Pulmonary Embolism, Hypertension and Intestinal Clostridium Difficile. Medical record review of the Minimum Data Set (MDS), dated June 17, 2011, revealed the resident had short term memory loss; no long term memory problem, modified independence with decision making skills; required extensive assistance for transfers and mobility and did not	F 221	Statement of Compliance: To remain in compliance with all state and federal regulations, The Center on Aging and Health has taken or will take actions set forth in this POC. The POC constitutes the Center on Aging and Health's allegation of compliance such that all alleged deficiencies have or will be corrected by dates indicated.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 9/26/2011

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 require the use of restraints. Medical record review of the interdisciplinary progress notes, dated June 12, 2011, revealed the resident "...bumped right lower extremity on side rail causing a skin tear ...". Continued review of facility documentation, dated June 12, 2011, revealed measures taken to include "..add short pads to rails...". Review of the "Safety Measures/Restraint Evaluation and Monitoring" document, revealed on July 27, 2011, "..safety measures reviewed. Continue with pad alarm in bed &...padded side rails ...". Observation of the resident on August 1, 2011, in the resident's room, at 2:20 p.m. and 4:35 p.m., revealed the resident lying on the bed, with bilateral padded side rails in the up position and a bed alarm in use. Interview with the MDS Coordinator and Quality Assurance Coordinator, August 3, 2011, at 8:00 a.m., in the MDS office, confirmed the facility utilized two side rails with pads, which would be considered a restraint for the resident, and no restraint assessment had been completed. Resident #4 was admitted to the facility on February 20, 2007, with diagnoses including Dementia, Congestive Heart Failure, and Anxiety Disorder. Medical record review of a physicians order dated June 29, 2009, revealed "...Roll belt in bed and w/c (wheelchair)..." Observations on August 1, 2011, at 9:58 a.m.,	F 221	Restraint assessments done for resident # 3 on 8/1/2011, restraint reduction assessment done on resident # 4 By QA Nurse or Designee (Charge Nurse). All residents with orders for restraints will be audited and assessments for restraints and reduction will be completed by 8/19/2011. New residents will be assessed on admission by licensed nurses and reported to DON or designee. Licensed staff will be inserviced by DON or designee on assessment procedure by 9/9/11. Restraint reduction assessments will be done quarterly and on significant change by MDS Nurse or Designee. All residents with restraints will be audited monthly for assessments and compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 2 and August 2, 2011, at 8:20 a.m., in the resident room, revealed resident #4 sitting in bed with a soft belt (restraint) in place. Observation on August 2, 2011, at 2:02 p.m., revealed resident sitting in a wheelchair with a soft belt in place. Interview on August 2, 2011, at 10:01 a.m., at the East Wing Nurse's station, with certified nursing assistant (CNA) # 1 revealed, the resident uses the call light when needs assistance and had not attempted to get out of bed unassisted for several months. Interview on August 2, 2011, at 10:08 a.m., at the East Wing Nurse's station with Charge Nurse #1 revealed the resident had not attempted to get out of bed unassisted. Interview and medical record review with the Director of Nursing, on August 2, 2011, at 10:30 a.m., in the facility conference room confirmed the resident had not been assessed for a less restrictive device or restraint.	F 221	Compliance will be reviewed monthly by the QA Nurse and reported the QA committee monthly consisting of Administrator, Director of Nursing, Safety Director, and Department Managers, to the Medical Director quarterly.	9/14/11 & Ongoing
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279	Care Plan for resident # 9 was immediately updated to reflect dressing changes for right lower extremities skin tear. Care plan updated to reflect resident # 3 nutritional needs and bi-weekly weights by QA Nurse.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and interview, the facility failed to update the care plan to reflect a change in nutritional needs for one resident (#3), and failed to update care plan to reflect skin tears for one resident (# 9) of twenty-two residents reviewed. The findings included: Resident # 3 was admitted to the facility on May 20, 2010, and readmitted on July 6, 2011, with diagnoses of Congestive Heart Failure, Pulmonary Embolism, Hypertension and Intestinal Clostridium Difficile. Medical record review of the Weight Report and Dietary Progress Notes, dated July 26, 2011, revealed the resident had a 12 percent significant weight loss from June 6, 2011, through July 8, 2011. Medical record review of the Dietary Progress Notes, dated July 6 through August 4, 2011, revealed the facility obtained weekly weights on July 6, July 14, July 21, 2011, and "...moved to bi-weekly weights next due date 8/4/11". Medical record review of the Dietary Managers notes, dated July 7, 2011, revealed the	F 279	All care plans audited by QA Nurse to assure compliance required to attain or maintain resident's highest level of well being possible. Care plans will be updated daily with changes that occur with each resident by the MDS coordinator and Licensed Nurses. Licensed nurses will be in serviced by DON or designee by 9/9/2011.Care Plans audited weekly times four weeks for compliance by QA nurse or designee. Compliance will be monitored weekly times four weeks and monthly times three months by QA nurse or designee and reviewed by QA committee of Administrator, Director of Nursing, Safety Director, and Department Managers monthly and quarterly with Medical Director.	9/9/11 9/14/11 & Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 resident was to receive weekly weights and nutritional supplements were added. Medical record review of the care plan dated June 21, 2011 revealed "Altered nutrition: Potential for less than body requires...tolerated prescribed diet without weight loss,...consume enough food to maintain wt. & meet nutritional needs, and...weigh and monitor for any significant weight loss...". Further review revealed the care plan was updated on June 20. 2011, with changes in diet but no update regarding the resident's weight loss or additional nutritional supplements. Interview with the Director of Nursing and Dietary Manager, in the activities room, on August 3, 2011, at 10:10 a.m., confirmed the care plan had not been updated to reflect the resident's recent decline and nutritional needs. Resident # 9 was admitted to the facility on June 7, 2011, with diagnoses including Congestive Heart Failure, Osteoporosis, and Glaucoma. Observation on August 1, 2011, at 10:12 a.m., revealed resident #9 awake and alert in bed with a gauze wrap visible to the left lower leg. Medical record review of a Physician's order dated July 25, 2011, revealed, "... LL (left lower) leg 3 (three) ST (skin tears) areas cleanse with wound cleanser apply xeroform gauze and Kerlex wrap..." Interview with the Quality Assurance Nurse and the Minimal Data Set (MDS) coordinator on	F 279		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	860 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5 August 2, 2011, at 3:03 p.m., in the MDS office confirmed the care plan had not been updated to reflect the skin tears.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to follow the physician's order for one resident (#18) of twenty-two residents reviewed. The findings included: Resident #18 was readmitted to the facility on May 16, 2011, with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease and Sleep Apnea. Medical record review of the Minimum Data Set dated May 23, 2011, revealed the resident scored 12 out of 15 on the Brief Interview for Mental Status (cognitively intact), was independent with eating and required extensive assistance with activities of daily living. Medical record review of a Physician's order dated May 16, 2011, revealed the resident was to have Oxygen at 2 liters per minute per nasal cannula as needed for oxygen saturations less than 90% (percent). Medical record review of the Care Plan dated	F 281	Physician clarified oxygen orders for Resident # 18. New orders for oxygen were changed to 2 liters per minute by nasal cannula and O2 saturations every shift by charge nurse. Oxygen saturations were placed in MAR to monitor every shift on 8/1/2011. Resident's physician orders will be clarified to include liters per minute and O2 saturations by QA nurse or designee by 9/9/2011. Residents admitted with oxygen will be clarified for liters per minute and specific Doctor's orders for oxygen saturations by the licensed nurse upon admission. Licensed nurses will be in serviced on receiving, transcribing, and following physician's admission orders for oxyge and/or saturations by 9/9/2011 by DON or designee.	9/9/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 6 May 31, 2011, revealed,"...Monitor and observe for increased SOB (shortness of breath), administer Oxygen per MD (Physician) order or facility protocol..." Medical record review of the Medical Administration Record dated May 16, 2011, thru August 3, 2011, revealed no documentation of oxygen saturations or Oxygen use. Medical record review of the Interdisciplinary Progress Notes dated May 29, 2011, thru August 2, 2011, revealed the following documentation: May 29, at 11:00 a.m., "...O2 (Oxygen) infusing @ 2L via nc (at 2 liters by nasal cannula)...O2 sats (oxygen saturation) 94%..." ; July 22, at 2:30 a.m., "...O2 at 2 L/min N/C ..." with no documentation of the oxygen saturation; and July 23, at 1:10 a.m., "...O2 @ 2 L/Min..." with no documentation of the oxygen saturation. Observations on August 1, 2011, at 10:40 a.m. and 10:42 a.m., and on August 2, 2011, at 10:48 a.m., in the resident's room, revealed the resident in the bed with Oxygen in use at 1.5 liters per minute per nasal cannula. Interview with Licensed Practical Nurse (LPN) #1 on August 2, 2011, at 10:48 a.m., in the resident's room, revealed the resident used the oxygen at all times and had a portable oxygen tank connected to the electric wheelchair for use when out of bed. Interviews with LPN #2 on August 2, 2011, at 3:55 p.m., at the nurses' station; with the Assistant Director of Nursing (ADON) on August 2, 2011, at 4:30 p.m., in the ADON's office, and	F 281	Compliance will be monitored weekly times four weeks and monthly times three monthly by QA Nurse or designee. QA committee of Administrator, Director of Nursing, Safety Director, and Department Managers and quarterly with Medical Director.	9/14/11 & Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 7 with the Director of Nursing (DON) on August 3, 2011, at 8:40 a.m., in the DON's office, confirmed the facility had not documented oxygen saturations before applying Oxygen and had not followed physician's orders for the application and use of Oxygen administration.	F 281		
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review and interview, the facility failed to re-calculate nutritional needs and obtained weekly weights for one resident (#3) with significant weight loss of twenty two residents reviewed. The findings included: Resident #3 was admitted to the facility on May 20, 2010, and readmitted on July 6, 2011, with diagnoses of Congestive Heart Failure (CHF), Pulmonary Embolism, Hypertension and Intestinal Clostridium Difficile (C. Diff). Medical	F 325	Nutritional assessment was completed by Dietary Manager resident # 3 and Care Plan updated to reflect current malnutrition needs on 8/3/2011. Residents that are at risk will be identified by a dietary assessment, base line labs, and significant weight change form then referred to nutrition at risk committee (Director of Nursing, Dietary Supervisor, or their designee and Dietician) every two weeks. At risk residents will be monitored as determined by nutrition at risk committee. Nutritional assessments will be completed on current resident by 8/31/2011.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 326	Continued From page 8 Record review revealed resident had been transferred to the hospital for evaluation and admission on May 31, June 27, and August 2, 2011, related to decreased urinary output, recurrent urinary tract infections (UTI) and fluid overload. Medical record review of the Registered Dietician's Interdisciplinary Progress Note, dated July 25, 2011, revealed "... reviewed for wt. (weight) loss. Wt 6/16/11- 124.4# (pounds). 7/8/11- 110.8# (-13.6). Wt now below IBWR (Ideal Body Weight Range) 118-142#. Intakes mostly 75-100% (percent). Resident recently out of hospital and back 7/6/11- dx (diagnosis), CHF, UTI and C. Diff, wt loss possibly due to fluid loss and/or C.Diff...". Medical record review of the Weight Report and Dietary Progress Notes, dated July 26, 2011, revealed the resident had a 12 percent significant weight loss from June 6, 2011, through July 8, 2011. Medical record review of the Dietary Progress Notes revealed the facility obtained weekly weights on July 6, July 14, July 21, 2011, and " ...moved to bi-weekly weights next due date 8/4/11". Medical record review of the Dietary Mangers notes, dated July 7, 2011, revealed the resident was to receive weekly weights, nutritional supplements were added, and no re-calculation of estimated nutritional needs had been completed. Observation on August 1, 2011, in the residents room, revealed the resident in the bed, alert, and a container of water was sitting on an over bed table near the resident. Review of facility policy "Significant Weight Loss" dated 2006, revealed	F 325	Assessments will be reviewed and revised as needed on admission, quarterly, and significant change. Compliance will be monitored weekly times four then monthly times three by DON or designee and reported to QA committee of Administrator, Director of Nursing, Safety Director, and Department Managers and quarterly with Medical Director.	9/14/11 & Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 9 "...place resident on weekly weights for one month and review these weights weekly and re-calculate estimated nutritional needs ...". Interview with the Director of Nursing and Dietary Manager, in the activities room, on August 3, 2011, at 10:10 a.m., confirmed the facility did not follow facility policy in obtaining a full month of recorded weights for the resident and did not re-calculate the residents estimated nutritional needs following a recent medical decline and significant weight loss.	F 325		
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store foods in a sanitary manner for one of two refrigerators, and failed to maintain equipment in a sanitary manner for the ice machine, standing mixer and toaster in the dietary department. The findings included: Observation and interview on August 1, 2011, at	F 371	No residents affected by deficiency. All food storage areas were inspected; expired creamers and steak fingers were discarded. Milk expired was given back to company for credit. The standing mixer and toaster were cleaned immediately. Filters were cleaned immediately. Dietary Staff will monitor all food storage areas to include refrigerators and freezers for preparations dates and expirations dates on 8/1/2011.	9/14/11 per adm.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	860 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 10 9:55 a.m., with the Dietary Manager, in the dietary department, confirmed the outside filter and vent on the ice machine was visibly covered with dust particles and needed to be cleaned. Observation and interview, on August 1, 2011, at 10:05 a.m., with the Dietary Manager, in front of the reach in refrigerator in the dietary department, confirmed a "half full pan of steak fingers" in a metal serving pan, cooked, covered with aluminum foil, and no date or time of preparation or expiration. Further observation and interview confirmed a half gallon of unopened whole milk with an expiration date of July 30, 2011. Further interview confirmed no date the "steak fingers" had been prepared, and the milk was available for resident use beyond the expiration date. Observation and interview on August 1, 2011, at 10:15 a.m., with the Dietary Manager, in the walk in refrigerator in the dietary department, confirmed two full gallons of buttermilk with expiration dates of July 21, 2011, and one full gallon of milk with an expiration date of July 30, 2011. Further observation confirmed one box containing 360 individual coffee creamers with an expiration date of June 30, 2011, and a serving pan that had a soft cucumber with "numerous white spots" covering the entire surface area of the cucumber. Further observation/interview confirmed a freezer company tag hanging from the roof of the refrigerator that was black, moist and unreadable. Interview with the Dietary Manager confirmed the milk was available for use beyond the expiration date; the cucumber was spoiled and the freezer company tag was unsanitary.	F 371	Daily check sheets will be completed by dietary staff to remove all expired items. Appliances including toaster will be cleaned after each use. All ice machine filters will be cleaned daily by dietary staff. Dietary Manager will monitor for compliance weekly times four weeks then monthly. Compliance will be reviewed by QA committee monthly of Administrator, Director of Nursing, Safety Director, and Department Managers, and quarterly with Medical Director.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	860 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 Observation and Interview, on August 1, 2011 at 10:30 a.m., with the Dietary Manager, in the dietary department, confirmed the standing mixer had an "orange colored particle" on the inside of the top of the mixer and the back of mixer wall, and the toaster had "black dried crust" on the roller blades. Interview with the Dietary Manager confirmed the mixer and toaster were available for food preparation and needed cleaning.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview the facility failed to follow facility policy for infection control for nebulizer use for one resident (#13) and failed to follow facility policy for infection control for oxygen tubing use for one resident (#18) of twenty-two residents reviewed. The findings included: Observation on August 1, 2011, at 9:48 a.m., revealed the nebulizer and nebulizer tubing for resident #13 was uncovered and the nebulizer tubing was undated. Observation and interview with Charge Nurse #2 on August 1, 2011, at 1:59 p.m., in the resident's room, confirmed the nebulizer for resident #13 was uncovered and should have been placed in a plastic storage bag when not in use. Review of the facility policy for Nebulizer Treatment revealed, "...dismantle the nebulizer and rinse it under a stream of water. Allow the nebulizer to air dry, then reassemble it and place it and tubing in a plastic bag. Change tubing and	F 441	Mentioned nebulizer for resident #13 was removed from room, cleaned and new tubing dated and placed on nebulizer by CNA. Nebulizer and tubing were placed in plastic storage bag on 8/1/2011. O2 tubing was replaced with new tubing immediately for resident # 18 on 8/1/2011. Residents receiving nebulizer treatment and oxygen were checked for proper storage and dates of tubing change by C.N.A. mentor. C.N.A. mentor will in service other C.N.As on policy for tubing changing and storage of nebulizer and O2. Charge nurses will check all oxygen tubing and nebulizers during A.M. med pass for compliance daily to assure nebulizer tubing and equipment are in plastic bag. Nebulizer and O2 tubing will be replaced and dated every week.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER ON AGING AND HEALTH	880 SOUTH MOHAWK DRIVE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 bags weekly..." Interview with the Director of Nursing (DON) on August 2, 2011, at 9:09 a.m., at the east hall nursing station, confirmed the facility policy for nebulizers was not followed. Resident #18 was readmitted to the facility on May 16, 2011, with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease, and Sleep Apnea. Medical record review of a Physician's order dated May 16, 2011, revealed Oxygen at 2 liters per minute per nasal cannula as needed for oxygen saturations less than 90% (percent). Observation on August 2, 2011, at 10:20 a.m. until 10:48 a.m., revealed the resident was lying in bed asleep, with the oxygen concentrator setting at 1.5 liters per minute, and the oxygen tubing was lying in the floor, behind the bed, and not available for resident use. Observation revealed three separate occasions staff entered/exited the resident's room without observing/intervening to remove the dirty oxygen tubing that continued to lie on the floor. Observation and Interview on August 2, 2011, at 10:48 a.m., in the resident's room, with Licensed Practical Nurse #1, confirmed the oxygen tubing was lying on the floor and the oxygen tubing was unsanitary.	F 441	Compliance will be monitored by C.N.A. mentor weekly and reviewed by QA committee of Administrator, Director of Nursing, Safety Director, and Department Managers monthly and quarterly with Medical Director.	9/14/11 & Ongoing